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· .				1/10/06 Pol the	PRINTERN	D: 06/25/2008 1 APPROVED		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SAND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILOII	TIPLE CONSTRUCTION F.C.	(X3) DATE	ATE SURVEY OMPLETED	
	NVN556S			B. WING		06/	13/2008	
NAME OF	PROVIDER OR SUPPLIER		1		STATE, ZIP CODE			
HEARTH	ISTONE OF NORTHE	RN NEVADA		NV 89434				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETÉ DATE	
Z 000	Initial Comments	•		2 000		*****		
	; the result of a State	Deficiencies was gen e licensure survey co 6/9/08 through 6/13	nducted					
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:				RECEIV			
					JUL 0 8 20			
					BUREAU OF LICEN: AND CERTIFICAT CARSON CITY, NEV	IU31V		
							22 52 54	
Z342	NAC 449.74511 Personnel Records - Licenses, TB, Background 3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: a) Evidence that the employee has obtained any license, certificate or registration, and possesses the experience and qualifications, required for the position held by the employee; b) Such health records as are required by chapter 441A of NAC which include evidence that the			Z342	Z 342 PERSONNEL RECOR		7/3/08	
					CORRECTIVE ACTION:			
				14	Employee # 10 is no longer a employee of the facility.	ń		
					The facility has hired a full-ti Staff Development Coordinat to ensure training and educati facility staff follows regulation	tor ion for	9 -	
	employee has had accordance with N	as had a skin test for tuberculosis in with NAC 441A.375; and			IDENTIFICATION OF OTH			
	c) Documentation that the facility has not received any information that the employee has been convicted of a crime listed in paragraph (a)				All personnel and residents h		i	

This Regulation is not met as evidenced by: If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

of subsection 1 of NR\$ 449.188.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NVN556S						06/1	3/2008	
HEADTHSTONE OF NORTHERN NEVADA 1950 BAR			DRESS, CITY, STATE, ZIP CODE RING BLYD NV 89434					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
Z342	2 Continued From page 1 Based on record review and interview, it was determined that the facility failed to obtain tuberculosis testing in accordance with NAC 441A for 1 of 10 employees. (#10) Findings include: Employee #10: The employee was hired on 3/18/08. Review of the record failed to reveal evidence of tuberculosis testing. An interview with the staff development coordinator at approximately 2:00 PM on 6/12/08, confirmed that the facility had no evidence of tuberculosis testing. Severity 2 Scope 1			Z342	SYSTEMS CHANGES: The Staff Development Coordinator has developed a "tickler" system to monitor employee's required TB screens. Results will be recorded on the "Personnel Record Check List." MONITORING: The Staff Development Coordinator will report their findings to the monthly Performance Improvement Committee. Performance improvement plans will be implemented as needed		7/3/08	
Z393	provides care to per 1. Except as otherweach person who is skilled nursing whice with any form of der limitation, dementiation, since the person of the pers	iployees of facility wisons with demential ise provided in substantial employed by a facility in provides care to provide and caused by Alzheimerect contact with and any form of dementerified by an occupate complete the follow continuing education of demential employment with a first 30 days after imployment; and	ection 4, ity for ersons thout er's d provides itia and ational wing n a facility be the	Z393	JUL 08 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	:		

deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. 710011 TATE FORM

If continuation sheet, 2 of 4

of employment.

NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Z 000 Initial Comments This Statement of Deficiencies was generated as the result of a State licensure survey conducted at your facility from 6/9/08 through 6/13/08. Ten personnel records were reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 2 000 This Statement of Deficiencies was generated as the result of a State licensure survey conducted at your facility from 6/9/08 through 6/13/08. Ten personnel records were reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
HEARTHSTONE OF NORTHERN NEVADA 1950 BARING BLVD SPARKS, NV 89434			NVN556S		B. WING	B. WING 06/13/2008		
SPARKS, NV 89434 SPARKS, NV 89434	NAME OF PROV	IDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Z 000 Initial Comments This Statement of Deficiencies was generated as the result of a State licensure survey conducted at your facility from 6/9/08 through 6/13/08. Ten personnel records were reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG OF TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TAG OF	I MEVOTAGLUME DE MUDITHEDM MENVUN I I I I I I I I I I I I I I I I I I I							
This Statement of Deficiencies was generated as the result of a State licensure survey conducted at your facility from 6/9/08 through 6/13/08. Ten personnel records were reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be This Statement of Deficiencies was generated as the result of a State licensure survey conducted as the result of a State licensure survey conducted as the result of a State licensure survey conducted at your facility from 6/9/08 through 6/13/08. RECEIVED JUL 0 3 2008 BUREAU OF LICENSURE AND CERTIFICATION AND CERT	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE CO	MPLETE
avaitable to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified: Z342 NAC 449.74511 Personnel Records - Licenses, TB, Background 3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: a) Evidence that the employee has obtained any license, certificate or registration, and possesses the experience and qualifications, required for the position held by the employee; b) Such health records as are required by chapter 441A of NAC which include evidence that the employee has had a skin test for tuberculosis in accordance with NAC 441A.375; and c) Documentation that the facility has not received any information that the employee has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188.	This the at y Ter The by the property of the ider the pose b) S 441 emple according to the pose b) S 441 emple according to the pose b) S 441 emple according to the pose been the ider the pose b) S 441 emple according to the pose b) S 441 emple according to the identity of the identit	is Statement of E result of a State your facility from a personnel record findings and count for the Health Division of the Health Division of the relations or other claimable to any parte, or local laws. The following regulantified: C 449.74511 Person and according to the facility. The relation: Evidence that the inse, certificate on experience and ition held by the such health record A of NAC which coloyee has had a cordance with NA occumentation the evidence of a such convicted of a state of the convicted of the conv	e licensure survey co 6/9/08 through 6/13/ ords were reviewed onclusions of any investion shall not be constitued in a civil investigations for relief that mate the personnel records a constitution of the facility must be materially must be	estigation trued as tions, y be ederal, re censes, ord for aintained without ined any essesses ed for the electric the ulosis in twee has		BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA Z 342 PERSONNEL RECORDS-LICENSES, TB, BACKGROUNE CORRECTIVE ACTION: Employee # 10 is no longer an employee of the facility. The facility has hired a full-time Staff Development Coordinator to ensure training and education for facility staff follows regulations. IDENTIFICATION OF OTHERS All personnel and residents have the	Dr he	80 6

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION N			NUMBER: A. BUIL				(X3) DATE SURVEY COMPLETED	
		NVN556S		B. WING			3/2008	
NAME OF PROVIDER OR SUPPLIER STRE			STREET A	DDRESS, CITY,	STATE, ZIP CODE			
HEARTH	ISTONE OF NORTHE	RN NEVADA		RING BLVD , NV 89434				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
Z342	Continued From page 1 Based on record review and interview, it was determined that the facility failed to obtain tuberculosis testing in accordance with NAC 441A for 1 of 10 employees. (#10) Findings include: Employee #10: The employee was hired on 3/18/08. Review of the record failed to reveal evidence of tuberculosis testing. An interview with the staff development coordinator at approximately 2:00 PM on 6/12/08, confirmed that the facility had no evidence of tuberculosis testing. Severity 2 Scope 1 Personnel Training in Dementia		ain NAC ed on reveal erview at firmed	Z342	SYSTEMS CHANGES: New hire nursing competencies will now be completed during orientation week. Nursing competencies will be repeated annually. Competencies for current staff will be obtained during monthly competency fairs supervised by the Staff Development Coordinator, or their designee. The Human Resources Director is now using the form provided by the BCL. Current employees signed the new form. The new form (CHS) is now included in our new employee orientation packet.			
4	NAC 449.74522 Employees of facility which provides care to persons with dementia				The Staff Development Coord	linator has		

1. Except as otherwise provided in subsection 4, each person who is employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, who has direct contact with and provides care to persons with any form of dementia and who is licensed or certified by an occupational

specifically related to dementia: (a) In his first year of employment with a facility for skilled nursing, 8 hours which must be completed within the first 30 days after the

licensing board must complete the following

number of hours of continuing education

employee begins employment; and (b) For every year after the first year of employment, 3 hours which must be completed on or before the anniversary date of the first day of employment.

employee's required TB screens. Results will be recorded on the "Personnel Record Check List."

MONITORING:

The Staff Development Coordinator will report their findings to the monthly Performance Improvement Committee . Performance improvement plans will be implemented as needed

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 2 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM NVN556S			(X2) MULT A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED 06/13/2008		
The state of the s			DRESS, CITY.	STATE, ZIP CODE			
	ISTONE OF NORTHE	RN NEVADA	1950 BAF	RING BLVD NV 89434			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Z393	be completed pursu (a) Must be approve licensing board white person completing (b) May be used to education requirem licensing board and hours or units of red. 3. Each facility for seproof of completion education required personnel file of earlies required to completion to this sec. 4. A person employ nursing which proviform of dementia, in dementia caused by required to complete education specifical required pursuant to complete that trainmonths. 5. As used in this sespecifically related to the second of the se	attinuing education requant to this section: ed by the occupation och licensed or certificathe continuing educations at satisfy any continuing entry of an occupation of the continuing education of the hours of continuing education of the hours of continuing education. The design of the fact of the fact of the hours of continuing education. The design of the fact of the hours of continuing education of the hours of continuing education, "continuing education," continuing education, "continuing education,	al ed the ed the ation; and g nal lditional ucation. naintain inuing ion in the acility who ation illed with any tation, se, is not uing ia nas us 12	Z393	Z 393 PERSONNEL TRAINING CORRECTIVE ACTION The facility has hired a full-time S Development Coordinator to ensu training and education for facility staff follows regulations. On 6/23/08, the Staff Development Coordinator conducted the manda Alzheimer's Training. IDENTIFICATION OF OTHERS The Staff Development Coordinat will identify employees who need the annual Alzheimer's training (through a review of their employe personnel record. SYSTEMS CHANGES: The Staff Development Coordinat or their designee, will provide nev employees with the required 8 hot Alzheimer's training during their	Staff re nt ttory :: :or 3 hour) :e's	TIA
	(a) An overview of t including, without lir Alzheimer's disease	estruction regarding: he disease of demer mitation, dementia ca se, which includes ins prognosis and treatm	aused by struction		orientation week. The Staff Development Coordinat is now conducting the required Altraining monthly for employees.		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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disease;

dementia;

with dementia;

person with dementia; and

(b) Communicating with a person with dementia;

(d) Recreational and social activities for a person

(e) Aggressive and other difficult behaviors of a

(f) Advising family members of a person with

(c) Providing personal care to a person with

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MONITORING:

implemented as needed.

The Staff Development Coordinator will

Performance Improvement Committee.

Performance improvement plans will be

report their findings to the monthly

If continuation sheet 3 of 4

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		, ,	(X3) DATE SURVEY COMPLETED	
	NVN556S			B. WING_		06/1	06/13/2008	
NAME OF PROVIDER OR SUPPLIER STREET ADI				DRESS, CITY,	STATE, ZIP CODE			
HEARTH	STONE OF NORTHE	RN NEVADA		NV 89434				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETE DATE		
Z393	Z393 Continued From page 3 dementia concerning interaction with the person with dementia.			Z393				
	Based on record redetermined that the dementia training in	not met as evidence view and interview, it facility failed to prove accordance with NA10 employees. (#2, 1	was ide C					
	Findings include:							
	3/10/97. Review of failed to reveal docu	employee was hired of the employee's persumentation that the reading was completed	onnel file equired					
	9/17/03. Review of the failed to reveal documents	employee was hired of the employee's perso umentation that the re aining was completed	onnel file equired					
	Employee #4: The employee was hired on 3/9/04. Review of the employee's personnel file failed to reveal documentation that the required annual dementia training was completed.							
The same	On 6/22/08 at approximately 2:00 PM, the staff development coordinator was interviewed and confirmed that there was no evidence that Employees #2, #3 and #4 completed the annual dementia training.		d and at					
Severity 2 Scope 2								

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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